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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

Ubaldo Trujillo,

Plaintiff,

V.

Nancy A. Berryhill,
Acting Commissioner of Social Security,

Defendant.

No. CV-15-0223-TUC-BGM

ORDER

Currently pending before the Court is Plaintiff's Opening Brief (Doc. 21).

Defendant filed her Responsive Brief (“Response”) (Doc. 22), and Plaintiff filed his Reply Brief (“Reply”) (Doc. 23). Plaintiff brings this cause of action for review of the final decision of the Commissioner for Social Security pursuant to 42 U.S.C. § 405(g). The United States Magistrate Judge has received the written consent of both parties, and presides over this case pursuant to 28 U.S.C. § 636(c) and Rule 73, Federal Rules of Civil Procedure.

• • •

1 **I. BACKGROUND**

2 **A. Procedural History**

3 On July 11, 2011,¹ Plaintiff filed a Title II application for Social Security
4 Disability Insurance Benefits (“DIB”), as well as a Title XVI application for
5 Supplemental Security Income (“SSI”), alleging disability as of April 30, 2008² due to
6 headaches, anxiety, seizures, and head trauma. *See* Administrative Record (“AR”) at 11,
7 33–34, 72–77, 91–92, 114, 117, 187, 194, 219, 232. Plaintiff’s date last insured is
8 December 31, 2012. *Id.* at 11, 13, 76, 219, 228, 263, 294. The Social Security
9 Administration (“SSA”) denied this application on November 10, 2011. *Id.* at 11, 71–73,
10 108–12. Plaintiff filed a request for reconsideration, and on January 12, 2012, SSA
11 denied Plaintiff’s application upon reconsideration. *Id.* at 11, 74–105, 113–20. On
12 January 17, 2012, Plaintiff filed his request for hearing. *Id.* at 11, 121–22. On April 30,
13 2013, a hearing was held before Administrative Law Judge (“ALJ”) Myriam C.
14 Fernandez Rice. AR at 11, 28–70. On August 7, 2013, the ALJ issued an unfavorable
15 decision. *Id.* at 8–22. On October 11, 2013, Plaintiff requested review of the ALJ’s
16 decision by the Appeals Council, and on March 23, 2015, review was denied. *Id.* at 1–7.
17 On May 28, 2015, Plaintiff filed this cause of action. Compl. (Doc. 1).

24 ¹ In her opinion, the Administrative Law Judge (“ALJ”) states that the claimant applied
25 for benefits on July 11, 2011; however the various forms and summaries contained in the record
26 are inconsistent and indicate application dates of July 11, 2011, as well as July 15, 2011. AR at
27 11, 72–75, 187, 194.

28 ² At the hearing before the ALJ the claimant amended his alleged onset date to January 1,
2010. AR at 33. The ALJ noted this change to January 20, 2010 in her decision; however, the
court relies on the hearing transcript and finds January 1, 2010 to be Plaintiff’s alleged onset
date. *Id.* at 11, 33.

1 ***B. Factual History***

2 Plaintiff was fifty-two (52) years old at the time of the administrative hearing and
3 forty-nine (49) at the time of the alleged onset of his disability. AR at 33, 72–76, 91,
4 187, 194, 219, 263. Plaintiff has a ninth grade education and obtained a GED. *Id.* at 33,
5 72–75. Prior to his alleged disability, Plaintiff worked as a laborer, cement finisher, and
6 floor hand. *Id.* at 33, 208–18, 222–30, 233, 277.
7

8 **1. Plaintiff's Testimony**

9 **a. Administrative Hearing**

10 At the administrative hearing, Plaintiff testified that he is married, and his wife is
11 on benefits. AR at 36–37. Plaintiff further testified that his wife had a stroke resulting in
12 both mental and physical disability, and they tried to take care of one another. *Id.* at 37.
13 Plaintiff has no other source of income. *Id.* at 36–37. Plaintiff is not supposed to drive
14 due to his seizure condition, but does sometimes. *Id.* at 37. Plaintiff testified that he has
15 trouble sleeping at night, and on a typical day he and his wife will read the Bible
16 together, eat lunch, watch a movie or some television, eat supper, and get ready for bed.
17 *Id.* at 37–38, 55. Plaintiff testified that both he and his wife do chores, such as cooking,
18 cleaning, and grocery shopping. AR at 38. Plaintiff further testified that he cannot spend
19 much time in a store to shop, because of his panic attacks. *Id.* at 47–49. Plaintiff testified
20 that to accommodate this issue, he and his wife try to shop early or late in the day. *Id.* at
21 49. Plaintiff also testified that the few times that he and his wife have gone to see a
22 movie, he could not comprehend what was happening on the screen. *Id.* at 50. Plaintiff
23 testified that this happens when he watches movies or television at home, too. *Id.* at 54.
24

1 During the hearing, Plaintiff had difficulty remembering the precise title of his last
2 job as a laborer. AR at 33–34. Plaintiff testified that he was laid off in conjunction with
3 having a seizure while walking down the stairs at work. *Id.* at 34, 42. Plaintiff further
4 testified that he takes seizure medication, as well as medication for depression and
5 anxiety, and headaches. *Id.* at 35–36, 53–54, 62. Plaintiff also testified that he can no
6 longer work as a cement finisher, because he cannot read blueprints or do the necessary
7 calculations, cannot pay sufficient attention, and he suffers from neck and back pain. *Id.*
8 at 38–39, 56. Plaintiff’s work as a cement finisher also involved supervising
9 approximately ten (10) to twenty (20) people. *Id.* at 64–65. Plaintiff testified that he no
10 longer uses drugs or alcohol, but does not remember when he last used. *Id.* at 39–40.
11

12 Plaintiff further testified that his seizures had been controlled over the previous
13 five (5) months, likely because of a change in his medication. AR at 40. Plaintiff
14 testified that prior to that he would have seizures once or twice a week. *Id.* at 41.
15 Plaintiff stated that he has grand mal seizures, which cause him to lose consciousness for
16 approximately one (1) hour. *Id.* at 42–43. Plaintiff testified that having seizures at work
17 made it so he could not do his job. *Id.* at 43. Plaintiff indicated that when he was a
18 foreman taking breaks was a possibility; however, this is not an option for regular
19 laborers. *Id.* at 44. Plaintiff further testified that despite the fact that his seizures are
20 better controlled, they would still be a problem at work. AR at 45–46.
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22 Plaintiff also testified that he also suffers from anxiety and panic attacks. *Id.* at
23 46–47. Plaintiff further testified that when a panic attack occurs he suffers from
24 dizziness, sweating, and a change in breathing. *Id.* Plaintiff testified that sometimes his
25

1 panic attacks prevent him from sleeping. *Id.* at 48, 51. Plaintiff further testified that
2 although the frequency of his panic attacks has been reduced by medication, they still
3 occur. *Id.* at 50. Plaintiff also testified that he cannot sleep through the night, and will
4 wake up after a couple of hours thinking that his world is going to end. AR at 51.
5 Plaintiff testified that it takes a long time to go back to sleep after this occurs, and can
6 take as long as an hour and a half to two (2) hours. *Id.* at 52. Plaintiff further testified
7 that this affects his mood swings, and he often suffers from bad moods. *Id.* Additionally,
8 Plaintiff described incidents at work resulting in fights, because he does not like to “take
9 orders” from anyone. *Id.* at 57–58. Plaintiff also testified that he has trouble
10 remembering things, such as conversations or activities. *Id.* at 56–57.
11

12 Plaintiff testified that he suffers from daily headaches, but does not have a specific
13 medication to treat them. AR at 58–59. Plaintiff takes Naproxen to treat both his
14 headaches and his back. *Id.* at 59. Plaintiff further testified that he has had these
15 headaches since being hit on the head with a tire iron. *Id.* at 59–60. Plaintiff also
16 testified that previously some supervisors would allow him to take off from work when
17 he had a headache, but others would be angry. *Id.* at 60.
18

19 Plaintiff testified that his depression makes him feel like giving up. *Id.* at 61.
20 Plaintiff further testified that he does not have any hobbies aside from reading the Bible,
21 but his appetite is good. AR at 61–62. Plaintiff also testified that he has thought about
22 taking his own life, and continues to have those thoughts. *Id.* at 62.
23

24 **b. Administrative Forms**
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26 On July 20, 2011, Plaintiff completed a Function Report—Adult in this matter.
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1 He indicated that he lived with a friend, made his bed, water to the lawn, and cleaned up.
2 AR at 241. On the same date, Plaintiff completed a Seizure History form. *Id.* at 243–45.
3 Plaintiff described his seizures as feeling like electricity is flowing through his head and
4 sometimes throughout his entire body. *Id.* at 243. Plaintiff stated that he has seizures
5 once or twice per week, but does not remember the dates of his last three (3) seizures. *Id.*
6 Plaintiff described a shocking feeling as the warning sign before the seizure begins. *Id.*
7 During the seizure, Plaintiff passes out, loses control of his urine, and has been told that
8 he shakes. AR at 243. Plaintiff indicated that his seizures usually occur at night and vary
9 in length. *Id.* Plaintiff confirmed that he stares into space for short period of time
10 without falling or shaking, and reported feeling lost and unable to remember anything
11 after the seizure. *Id.* Plaintiff listed several seizure medications, including
12 Carbamazepine, clonazepam, and trazodone, and indicated that he usually takes the
13 medication as directed. *Id.* Plaintiff noted that it has been about two (2) years since he
14 last used alcohol or drugs. *Id.* Plaintiff also indicated that he is seeking help from a
15 psychologist. *Id.*

16 Plaintiff also completed a Headache Questionnaire. AR at 246–52. Plaintiff
17 testified that he has headaches once or twice a day that feel like the top of his head is
18 going to explode. *Id.* at 246. Plaintiff described a sound “like a train whistle going off”
19 occurring prior to or during the headaches, with the pain located on the top of his head
20 and sometimes on his temples. *Id.* Plaintiff stated that he takes “lots and lots of Tylenol”
21 and uses cold water to relieve the symptoms. *Id.* Plaintiff further indicated that stress
22 makes the headaches worse, and they sometimes last all day. *Id.*

1 Plaintiff stated that he does not get along with anyone and does not like people
2 telling him what to do. AR at 247. Plaintiff further noted his anxiety and poor ability to
3 handle stress or changes in routine. *Id.* Plaintiff also noted that he relies on glasses or
4 contact lenses for reading. *Id.* Plaintiff indicated that he angers easily and does not like
5 to socialize. *Id.* at 248. Plaintiff further indicated that he cannot hear very well, his
6 eyesight has gotten “real bad,” he is forgetful, he has trouble understanding, and cannot
7 stand being around others. *Id.* Plaintiff also stated that he was having difficulty filling
8 out the form. AR at 248. Plaintiff testified that he can concentrate for approximately
9 thirty (30) minutes to one (1) hour, but has difficulty following instructions. *Id.*
10

11 Plaintiff listed his previous activities as playing cards, fishing, and watching
12 television. *Id.* at 249. Plaintiff stated that he was good at those things; however, now he
13 loses interest quickly. *Id.* Plaintiff further stated that he speaks with his brother on the
14 phone once a week, but does not go anywhere else on a regular basis. *Id.* Plaintiff
15 testified that he needs to be reminded to go places, but does not need anyone to
16 accompany him. AR at 249. Plaintiff stated that when he goes out he walks or rides in a
17 car, but does not drive because he does not have a driver’s license. *Id.* at 250.
18

19 Plaintiff further stated that he shops in stores approximately twice per month for
20 one (1) to two (2) hours for groceries. *Id.* Plaintiff also noted that he is able to pay bills,
21 count change, and handle a savings account; however, he cannot use a checkbook due to
22 a lack of funds. *Id.* Plaintiff testified that he needs reminders to take his daily
23 medication. *Id.* at 251. Plaintiff prepares his own meals once or twice a day, making
24 mostly sandwiches. AR at 251. Plaintiff testified that this meal preparation takes him
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1 approximately twenty (20) minutes. *Id.* Plaintiff also stated that he forgets about having
2 the stove on. *Id.*

3 Regarding household chores, Plaintiff testified that he makes his bed, takes the
4 garbage out, and waters the lawn. *Id.* Plaintiff stated he performs these tasks daily and it
5 takes him approximately four (4) hours to complete. *Id.* Plaintiff also indicated that he
6 does not care for other people or pets. AR at 252. Plaintiff testified that he can no longer
7 work cement or as a laborer. *Id.* Plaintiff also stated that he has trouble sleeping, and
8 gets a shocking feeling when he tries to go to sleep which scares him. *Id.* Plaintiff did not
9 indicate any problems with personal care, although he has trouble remembering where he
10 puts things. *Id.*

11 On December 19, 2011, Plaintiff filled out a second Seizure History form. *Id.* at
12 274–75. Plaintiff again described his seizures as feeling like electricity is flowing
13 through his body, and also noted a loss of feeling in his left leg and arm and pressure in
14 his head. AR at 274. Plaintiff noted that the frequency of his seizures vary, and could
15 not remember the dates of his last three (3) seizures. *Id.* at 274. Plaintiff described
16 feeling like electricity begins hitting his body prior to the onset of the seizure. *Id.*
17 Plaintiff reported that he sometimes passes out during the seizure and sometimes loses
18 control of his urine. *Id.* Plaintiff also stated that he was told that he shakes during the
19 seizure. *Id.* Plaintiff further reported that the seizures occur both during the day and at
20 night and vary in length. AR at 274. Plaintiff described feeling lost after having a
21 seizure. *Id.* Plaintiff stated that he has used alcohol or street drugs in the past; however,
22 does not remember the last time he used them, estimating it was approximately ten (10)

1 years ago. *Id.* Plaintiff listed two seizure medications, Carbamazepine and lamotrigine,
2 and indicated that he always takes the medication as directed. *Id.* Plaintiff apologized
3 for his inability to remember things or events, noting that his brain does not work “that
4 great.” *Id.* at 275. Plaintiff also stated that filling out these forms causes him a great deal
5 of stress. *Id.*

6
7 On the same date, Plaintiff completed a second Function Report—Adult in this
8 matter. AR at 287–293. Plaintiff stated that he lived with his son. *Id.* at 287. Plaintiff
9 described his daily activities as waking up; making his bed; taking a shower; sometimes
10 eating; taking his medication; cleaning house if he is feeling well; feeding the dog;
11 watching television; and keeping to himself. *Id.* Plaintiff noted that he does not care for
12 any other people, but feeds his son’s dog and gives her water. *Id.* at 288. Plaintiff stated
13 that he is no longer able to work because of his illness. *Id.*

14
15 Plaintiff described sometimes feeling jolts of electricity in his head, which affects
16 his sleep. *Id.* Regarding personal care, Plaintiff stated that he is afraid of having a
17 seizure in the shower; that it hurts to comb his hair; and that brushing his teeth sometimes
18 gives him jolts of electricity in his head. AR at 288. Plaintiff indicated that he needs
19 reminders for appointments and to take his medication. *Id.* at 289. Plaintiff stated that he
20 prepares meals daily, consisting of mostly sandwiches, and taking approximately ten (10)
21 to twenty (20) minutes to prepare. *Id.* Plaintiff further stated that he is scared to use the
22 stove. *Id.* Plaintiff stated that he can vacuum, sweep, and mop. *Id.* These tasks take him
23 approximately seven (7) hours, once per week, and he sometimes needs a reminder. AR
24 at 289. Plaintiff stated that he goes outside approximately four (4) times per day. *Id.* at
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1 290. Plaintiff further stated that he walks and rides in a car, but does not drive because he
2 is afraid of having a seizure. *Id.* Plaintiff shops twice per month at the store for
3 groceries, and the amount of time it takes varies. *Id.* Plaintiff indicates that he is unable
4 to pay bills, count change, handle a savings account, or use a checkbook, because he does
5 not have any money. *Id.*

7 Plaintiff listed his previous activities as playing cards and watching television.
8 AR at 291. Plaintiff stated that he watches television daily. *Id.* Plaintiff further stated
9 that he speaks with family and attends church on Sundays. *Id.* Plaintiff noted that he
10 does not need to be reminded to go places or need anyone to accompany him. *Id.*
11 Plaintiff indicated that he has a bad temper and cannot work like he used to. *Id.* at 292.

14 Plaintiff described his illness as affecting his ability to lift; stand; walk; sit; talk;
15 see; remember; concentrate; understand; follow instructions; and get along with others.
16 AR at 292. Plaintiff stated that he can walk approximately 500 yards before needing to
17 stop and rest, and requires approximately ten (10) minutes of rest before he can resume
18 walking. *Id.* Plaintiff indicated that he does not know how long he can pay attention, but
19 sometimes can finish what he starts. *Id.* Plaintiff stated that he does not get along well
20 with authority figures, and has been fired or laid off from a job because of problems with
21 getting along with other people and not liking to be told what to do. *Id.* at 293. Plaintiff
22 does not handle stress or changes in routine well, and suffers from anxiety. *Id.* Plaintiff
23 stated that he does not currently use any assistive devices, but could use a cane. AR at
24 293.

25 . . .

2. Vocational Expert Cornelius Ford's Testimony

Mr. Cornelius J. Ford testified as a vocational expert at the administrative hearing. AR at 20, 63. Mr. Ford described Plaintiff's past work as a mining laborer, Dictionary of Occupational Titles ("DOT") number 921.667-018, as heavy exertion, and a Specific Vocational Preparation ("SVP") of 2, unskilled. *Id.* at 65. Mr. Ford described Plaintiff's other past work as a floor hand, DOT number 939.687-018, as a very heavy exertional level, SVP of 1, unskilled. *Id.* Mr. Ford described Plaintiff's third past work position as a cement mason, DOT number 869.664-014, as a heavy exertion level, SVP of 4, semi-skilled. *Id.*

The ALJ asked Mr. Ford about a hypothetical individual with the same age, education, and vocational background as Plaintiff. *Id.* The ALJ asked Mr. Ford to describe any past work or other work for such an individual, with the additional limitations of “not climb[ing] ladders, ropes or scaffolds; avoid[ing] all exposure to unprotected heights; . . . [and] limited to simple, routine repetitive tasks, only occasional interaction with the public and coworkers; . . . not [working] in an isolated work area; his interaction would be to be [sic] occasional but he should not be in a place where he’s completely by himself[.]” *Id.* at 65–66. The ALJ further refined her hypothetical to request work in either the heavy or medium exertional level. AR at 66. Mr. Ford testified that such an individual would be able to do the job of laundry worker, DOT number 361.684-014, medium exertional level, and SVP of 2, unskilled. *Id.* Mr. Ford further testified that there are 367,000 laundry worker jobs available in the national economy, and 4,200 such jobs regionally. *Id.* Mr. Ford also testified to the availability

1 of the job of hand packer, DOT number 920.587-018, medium exertional level, SVP of 2,
2 unskilled. *Id.* Mr. Ford also testified that there are 377,000 hand packer jobs available in
3 the national economy and 1,400 such jobs regionally. *Id.* Mr. Ford testified to a third
4 example, an egg sorter, DOT number 732.686-010, medium exertional level, SVP of 1,
5 unskilled. AR at 67. Mr. Ford further testified that there are 112,000 egg sorter jobs
6 available in the national economy and 1,100 such jobs regionally. *Id.*
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8 The ALJ asked Mr. Ford a second hypothetical, assuming the same individual as
9 in hypothetical number one, with the additional limitation that due to a combination of
10 medical conditions and mental impairments this individual would be off task twenty (20)
11 percent of the work day, and inquiring whether such limitations would be tolerated in
12 employment. *Id.* Mr. Ford testified that none of the employers that he has worked with
13 would tolerate such limitations. *Id.*
14

15 Plaintiff's counsel reiterated the ALJ's second hypothetical to Mr. Ford, but
16 replaced the twenty (20) percent off task with two (2) hours off task. *Id.* at 67. Mr. Ford
17 testified that a person with such restrictions would not be employable. AR at 67–68.
18 Similarly, Plaintiff's counsel posed the same question with the individual off task
19 between one (1) hour up to several hours, and up to two (2) or three (3) times a week. *Id.*
20 at 68. Again, Mr. Ford testified that such an individual could not do any work. *Id.*
21

22 **3. Lay Witness Testimony**
23

24 On July 21, 2011, Dionne Lewis completed a Seizure Witness Report. AR at 253–
25 54. Ms. Lewis reported that when Plaintiff gets stressed or has anxiety, he usually has a
26 seizure. *Id.* at 253. Ms. Lewis further reported that sometimes Plaintiff feels them
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1 coming and sometimes he does not. *Id.* Ms. Lewis stated that she witnessed a seizure
2 that occurred in the evening while Plaintiff was outdoors doing yard work. *Id.* She
3 further indicated that she had witnessed many seizures, and although they mostly
4 occurred in the evening, they happened at all times during the day and varied in duration
5 from three (3) to ten (10) minutes. *Id.* Ms. Lewis reported that plaintiff described the
6 onset of a seizure as feeling badly and feeling an electric shock. AR at 253. Ms. Lewis
7 indicated that anxiety and shaking were the first things that would cause her to think
8 Plaintiff was going to have a seizure. *Id.* Ms. Lewis described Plaintiff as unconscious
9 for approximately ten (10) minutes and nonresponsive during a seizure, his arms and legs
10 shake, his face changes color, and his eyes shake and roll. *Id.* Ms. Lewis further stated
11 that she has witnessed Plaintiff falling and injuring himself during a seizure, biting his
12 tongue, crying out at the start of the seizure, losing bladder control, and body shakes. *Id.*
13 Ms. Lewis also stated that Plaintiff sometimes hesitates and stares into space for short
14 period without falling or shaking, and after a seizure he does not seem normal as if he is
15 lost and cannot remember where he is at or what happened. *Id.* Ms. Lewis reported that
16 after seizure Plaintiff is unable to speak, confused, and has obvious paralysis or weakness
17 of the arms and legs. AR at 254. Ms. Lewis further reported that Plaintiff just started
18 taking medication for the problem, and although the seizures are not daily, Plaintiff has
19 trouble remembering things and is very forgetful. *Id.*

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26 On the same date, Ms. Lewis completed a Function Report—Adult—Third Party
27 regarding Plaintiff. *Id.* at 255–62. Ms. Lewis stated that she has known Plaintiff for
28 twelve (12) years, and recently began helping him get to doctors and providing a roof

1 over his head. *Id.* at 255. Ms. Lewis reported that Plaintiff has restless nights and is up
2 between 4 and 6 a.m.; and during the day drinks coffee; tries to do yard and house work;
3 goes for walks; and does not sit still too long. *Id.* Ms. Lewis further reported that
4 Plaintiff does not care for any other people or animals. AR at 256. Ms. Lewis noted that
5 Plaintiff is unable to do concrete work, road construction, or rig work. *Id.* Ms. Lewis
6 further noted that once Plaintiff lies down and starts to relax, he begins feeling electric
7 shocks through his body. *Id.*

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10 Ms. Lewis noted that Plaintiff has no problems with his personal care, and he does
11 not need any reminders regarding the same. *Id.* at 256–57. Ms. Lewis further noted,
12 however, that Plaintiff cannot remember whether or not he has taken his medication. *Id.*
13 at 257. Ms. Lewis reported that Plaintiff can prepare his own meals as long as he is
14 feeling okay, but if he forgets what he is doing, he becomes frustrated and does not
15 finish. AR at 257. Ms. Lewis further reported that Plaintiff is more forgetful of where he
16 puts things and what he is doing since becoming ill. *Id.* Ms. Lewis also reported that
17 Plaintiff can do most things regarding household chores; however, when he becomes
18 anxious or has a seizure he cannot function. *Id.* In her opinion, chores usually take
19 longer than they should when Plaintiff is doing them. *Id.* Ms. Lewis also noted that
20 Plaintiff has low self-esteem. *Id.*

21
22 Ms. Lewis reported that Plaintiff goes out daily and either walks or rides in a car.
23 AR at 258. She further noted that while Plaintiff can go out alone, he cannot drive due to
24 his seizures. *Id.* Ms. Lewis stated that Plaintiff goes to the store and shops for himself
25 and for groceries; however, this activity takes longer than necessary and Plaintiff cannot

1 remember what he needs to get or what he is doing. *Id.*

2 Ms. Lewis listed Plaintiff's hobbies as fishing, camping, pool, television, and
3 playing outdoor sports. *Id.* at 259. Ms. Lewis further reported that on good days he is
4 able to do these things well, and on other days not at all. *Id.* Ms. Lewis opined that
5 Plaintiff is scared to work and is embarrassed by his seizure condition. *Id.* Ms. Lewis
6 stated that Plaintiff does spend time with others; however, he mostly stays to himself.
7 AR at 259. Ms. Lewis further stated that Plaintiff must be reminded to call, go to
8 appointments, take medication, and be reminded of what he is doing. *Id.*

9 Ms. Lewis described Plaintiff's family as very negative, and stated that Plaintiff
10 does not like to be around people. *Id.* at 260. Ms. Lewis noted that Plaintiff's illness
11 affects his standing, walking, talking, seeing, memory, completing tasks, concentration,
12 understanding, follow instructions, and getting along with others. *Id.* Ms. Lewis
13 additionally noted that when Plaintiff gets upset or nervous, he becomes shaky and is
14 unable to concentrate or remember. *Id.* Ms. Lewis also reported that Plaintiff cannot
15 follow written instructions without giving up. AR at 260. Ms. Lewis opined that
16 Plaintiff is able to get along with authority figures and that he has not lost his job because
17 of any issues with getting along with people. *Id.* at 261. Ms. Lewis further reported that
18 Plaintiff does not handle stress or changes in routine well, and gives up in avoidance of
19 stress or problems. *Id.* Ms. Lewis also reported that Plaintiff uses glasses for reading.
20 *Id.* Ms. Lewis stated that she knows Plaintiff suffers from a lot of anxiety, depression,
21 seizures, and headaches, as well as trouble concentrating and focusing. *Id.* at 262.
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1 **4. Plaintiff's Medical Records**

2 On April 1, 2007, Plaintiff was seen at the San Juan Regional Medical Center
3 emergency department. AR at 387–92. Plaintiff had been transported to the emergency
4 department via EMS, with a possible seizure. *Id.* at 387. Plaintiff was noted to be
5 confused, and unable to remember where he was when the seizure occurred, or answer
6 questions appropriately. *Id.* Plaintiff was reported to have consumed half of pint of
7 whiskey that day; however, he stated that he had only had one small drink and mild daily
8 alcohol use. *Id.* at 387–88. Plaintiff also had blood work done. *Id.* at 391–92. Plaintiff's
9 final diagnosis was probable seizure and alcohol abuse. AR at 389.
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12 On April 9, 2009, Plaintiff was seen at the San Juan Regional Medical Center
13 emergency department complaining of left eye pain. *Id.* at 375–86. Plaintiff reported
14 that he had been working outside in the wind the previous day. *Id.* at 375, 380. Plaintiff
15 was diagnosed with a corneal abrasion. *Id.* at 382–83. Plaintiff was treated and
16 discharged home, with instructions to follow up with an ophthalmologist. *Id.* at 382,
17 385–86.
18

19 On October 8, 2010, Plaintiff was seen at the San Juan Regional Medical Center
20 emergency department by Brett Ziercher, M.D. AR at 360–74, 393. Plaintiff stated
21 “today is his birthday and he did meth as well as had a six pack of beer to drink.” *Id.* at
22 360. Prior to arriving at the emergency department, Plaintiff had passed out. *Id.*
23 Plaintiff was given an electrocardiogram (“EKG”), and Dr. Ziercher noted a borderline
24 prolonged qt. *Id.* at 361–62, 372. Dr. Ziercher opined that follow up with cardiology
25 was appropriate, and diagnosed Plaintiff with acute alcohol intoxication and heart block.
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1 *Id.* at 362. Plaintiff was discharged to home and directed to follow up with Robert
2 Sprung, M.D. AR at 362, 364.
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4 On March 30, 2011, Plaintiff had blood work done, the results of which were
5 unremarkable. *Id.* at 322–23. On May 2, 2011, Plaintiff underwent an
6 electroencephalogram (“EEG”). *Id.* at 320–21, 326–27. Stephen W. Thompson, M.D.
7 noted that “[t]he record is abnormal because of spikes in the right central region in sleep.”
8 *Id.* at 321, 327. Dr. Thompson further noted “[w]hat may be a single right central spike
9 also occurs awake.” *Id.* Dr. Thompson found “[t]he record is considered to be suggestive
10 of the possibility of an epileptic tendency with the right central spike focus.” AR at 321,
11 327. Additionally, Dr. Thompson noted “the amplitude of the activity in the right central
12 region is higher than that in the left, both asleep and awake . . . probably [] secondary to a
13 skull defect in the right central region from previous surgery.” *Id.* Dr. Thompson further
14 found that during sleep “it can be discerned that there is some slowing in the right central
15 region . . . [which] is non-specific and indicative of possible abnormality in this region
16 and it is in the location of previous surgery following head trauma.” *Id.*
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18 On July 4, 2011, Plaintiff was seen at the San Juan Regional Medical Center
19 emergency department by Angela Mize, M.D. *Id.* at 330–59, 394–96, 473–507. Plaintiff
20 “arrived by stretcher via ambulance from Street [sic] accompanied by
21 EMT/paramedic[.]” *Id.* at 330, 473. Per the EMT, “police saw pt driving down the road
22 and had blood on his face, pt states fell down or someone hit him, doesn’t know, has been
23 drinking[.]” AR at 330, 473. Plaintiff complained of a possible assault, with moderate
24 pain, and the precipitating factors unknown. *Id.* at 333, 476. Plaintiff’s associated
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1 symptoms included nose pain, headache, and anxiousness. *Id.* Plaintiff suggested that
2 someone “slipped him drugs.” *Id.* Plaintiff’s drug screen was presumptively positive for
3 meth, amphetamine, and benzodiazepine. *Id.* at 335–36, 395, 478–79, 490. Plaintiff’s
4 chest x-ray was unremarkable. AR at 337–38, 397, 480–81, 492. Plaintiff underwent a
5 computed tomography (“CT”) scan of his head. *Id.* at 338–40, 481–82, 493, 514.
6 Plaintiff’s head CT showed “[c]hronic right frontal and right parietal infarcts[;]
7 [r]ight parietal craniotomy appears to be old[;]
8 [n]o ventricle dilation[;]
9 [n]o mass effect;
10 [n]o hemorrhage[;]
11 [n]o extra axial fluid collection.” *Id.* at 338, 339, 398, 481, 482, 493, 514.
12 Plaintiff also underwent a CT scan of his maxillofacial sinus, which showed a “[n]asal
13 bone fractures appeared to be acute[;]
14 [n]o other fracture[;]
15 [m]ild paranasal sinus mucosal thickening[;]
16 [o]rbital contents unremarkable[;]
17 [and] [n]o other finding.” *Id.* at 339, 340, 399, 482, 483, 494, 515. Plaintiff’s cervical spine CT indicated “[n]o fracture,
18 dislocation, disc herniation, or epidural hematoma[;]
19 [and] [n]o other finding.” *Id.* at 341,
20 400, 484, 495. After treatment Plaintiff’s condition was good, and he was discharged to
21 home. AR at 342, 485. On July 18, 2011, Plaintiff was seen by Roy Addington, CNP at
22 Presbyterian Medical Services. *Id.* at 403–04, 547–48. Plaintiff presented with seizure
23 and anxiety. *Id.* NP Addington noted that Plaintiff had a seizure the week prior because
24 he ran out of his prescription. *Id.* at 403. Plaintiff also reported daily suicidal ideation.
25 *Id.* at 404, 548. NP Addington changed Plaintiff’s medication to Tegretol and added
26 clonazepam and accompanied him to behavioral health for intake. AR at 404, 548. On
27 July 27, 2011, Plaintiff was again seen at the San Juan Regional Medical Center
28 emergency department. *Id.* at 455–72. Plaintiff complained of a headache with “electric

1 shock feeling over entire body” and a loss of memory. *Id.* at 455, 458. Plaintiff reported
2 his symptoms began one (1) week prior, described his pain at a six (6) out of ten (10), and
3 described the pain as stabbing. *Id.* Plaintiff further described his pain as stabbing, sharp,
4 and shooting, and reported blurred vision. *Id.* Plaintiff underwent another CT scan. AR
5 at 459–60, 463, 513, 552. Robert Orbelo, M.D. reported a “right parietal craniectomy[:]”
6 [u]nderlying right parietal encephalomalacia[:] [r]ight frontal encephalomalacia[:] [n]o
7 mass, hemorrhage, or extraaxial fluid collection[:] [and] [n]o change from 7/4/11.” *Id.*
8 Dr. Orbelo’s impression indicated “[n]o acute process.” *Id.* Brad Campbell, D.O.
9 diagnosed Plaintiff with a headache and acute depression, and discharged him to home.
10 *Id.* at 460–61.

11 On August 5, 2011, Plaintiff was seen by Timothy W. Henkels, CNP at
12 Presbyterian Medical Services for an office visit. *Id.* at 543–46. Plaintiff was seen for
13 medication refill, seizure, and back pain. AR at 543. NP Henkels noted that Plaintiff’s
14 seizures are aggravated by stress and that Plaintiff is a poor historian. *Id.* NP Henkels’s
15 physical examination of Plaintiff was generally unremarkable; however, NP Henkels
16 noted Plaintiff’s mild distress. *Id.* at 543–45. Regarding Plaintiff’s psychiatric
17 assessment, NP Henkels reported Plaintiff had a depressed affect; was negative for
18 anhedonia; was anxious; did not exhibit compulsive behavior; did not behave
19 appropriately for age; had a deficient fund of knowledge; had normal language; was not
20 in denial; not euphoric; not fearful; did not have flight of ideas; was not forgetful; did not
21 have thoughts of grandiosity; denied hallucinations; denied hopelessness; did not have
22 increased activity; was having severely impaired remote memory; had no mood swings;
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1 no excessive thoughts; no paranoia; had normal insights; exhibited normal judgment;
2 normal attention span and concentration; did not have pressured speech; and did not have
3 suicidal ideation. *Id.* at 545. NP Henkels also noted a moderately impaired short-term
4 memory. *Id.* Plaintiff was given a prescription for tramadol and baclofen for lumbago.
5 AR at 545.

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7 On September 21, 2011, Sandra E. Eisemann, Ph.D. performed a psychological
8 evaluation on Plaintiff. *Id.* at 406–12. Dr. Eisemann noted that Plaintiff was “referred
9 for evaluation of headaches, seizures, anxiety and head trauma in the 1980s.” *Id.* at 406.
10 Dr. Eisemann noted that Plaintiff looked distressed during the evaluation and was a poor
11 historian. *Id.* As background information, Dr. Eisemann reviewed a bloodwork report
12 from July 19, 2011 and a report from PMS dated July 18, 2011. *Id.* Dr. Eisemann also
13 reviewed Plaintiff’s traumatic brain injury due to an assault with a tire iron to the right
14 side of the head. AR at 406. Plaintiff “stated his main complaints were Seizures [sic],
15 headaches[,] and anxiety.” AR at 407. Plaintiff further stated that he “wants to work but
16 cannot do so due to his physical conditions.” *Id.* Plaintiff also reported poor memory
17 and an inability to remember to take his medications. *Id.* Dr. Eisemann noted that
18 Plaintiff’s “seizure disorder began in 1980 after the brain injury and surgery.” *Id.*
19 Plaintiff told Dr. Eisemann that he was unable to do anything, felt worthless, and his
20 concentration was poor. AR at 407. Plaintiff further reported “that the seizure disorder
21 [wa]s the reason he cannot work.” *Id.* Dr. Eisemann further noted that Plaintiff had a
22 head trauma and surgery in the 1980s when he was hit with a tire iron and paralyzed on
23 his left side for six months; however, Plaintiff does not remember anything about it. *Id.*
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1 As a result, Plaintiff had “two surgeries, one to remove[] bone and blood clots and
2 another to put a plate in his skull.” *Id.* Dr. Eisemann noted Plaintiff’s medications as
3 baclofen for muscle pain; tramadol and two medications that he had not filled due to
4 finances — Trazodone and carbamazepine. *Id.* Dr. Eisemann further noted that Plaintiff
5 reported that “he was a bad alcoholic since he was 12 years old and stopped drinking 8
6 months ago.” AR at 407. Dr. Eisemann described Plaintiff’s work history as “pouring
7 concrete, on the pipelines, and on an oil rig[,] . . . [laying] carpet[,] and [] labor.” *Id.* at
8 408. Dr. Eisemann noted Plaintiff’s general appearance as “a thin man who looked
9 anxious and distressed.” *Id.* Dr. Eisemann further noted that Plaintiff “was vague in his
10 descriptions and said ‘I don’t know’ often [,] . . . [and] seemed somewhat irritable during
11 the interview.” *Id.* Dr. Eisemann reported Plaintiff “oriented as to time, place, and
12 person.” *Id.* Dr. Eisemann described Plaintiff’s short-term memory as poor, but not his
13 long-term memory. AR at 408. Dr. Eisemann further reported that Plaintiff could not
14 correctly remember three objects after five minutes, but was able to do a digit span
15 forward and backwards. *Id.* Dr. Eisemann also reported that Plaintiff made no errors in
16 the serial 7’s; however, although he could spell the word WORLD correctly forward, he
17 could not do it in the reverse. *Id.* Dr. Eisemann reported Plaintiff’s fund of information
18 as low average or below, intelligence as low average or below, and speech and language
19 capabilities without problems. *Id.* at 409. Dr. Eisemann noted that Plaintiff felt
20 depressed and was always worried. *Id.* Dr. Eisemann further noted that Plaintiff thinks
21 of self-harm but did not have a current plan. AR at 409. Dr. Eisemann also noted that
22 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
23 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
24 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
25 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
26 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
27 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described
28 Plaintiff did not exhibit malingering or factitious behavior. *Id.* Dr. Eisemann described

1 Plaintiff's typical day as waking up; making coffee; fixing his bed; talking with his uncle;
2 watching game shows on television; making sandwiches for meals; doing some cleaning
3 and laundry; and going grocery shopping. *Id.* at 410. Dr. Eisemann noted that Plaintiff
4 had significant dental problems, but did not have money for repairs. *Id.* Dr. Eisemann
5 reported that Plaintiff stated his memory was not good, he loses interest in things easily,
6 and does not finish them, and is highly distractible and will not stay task. *Id.* Plaintiff
7 also stated that he was functioning better one year ago and now has no interest at all. AR
8 at 410. Dr. Eisemann diagnosed Plaintiff with Anxiety Disorder not otherwise specified;
9 Major Depressive Disorder, recurrent, moderate; and Alcohol Dependence (abstinent for
10 eight months). *Id.* Dr. Eisemann reported Plaintiff's GAF score as 55–60. *Id.* at 411.
11 Dr. Eisemann noted that it was "not clear how much of [Plaintiff's] cognitive issues are
12 due to the head injury when he was twenty-nine years old and how much has been from
13 alcohol abuse[,] [h]e continues to have seizures at this time as well." *Id.* Regarding
14 Plaintiff's work capacity, Dr. Eisemann opined that Plaintiff could understand short and
15 simple instructions, and is moderately limited in this area. *Id.* Dr. Eisemann further
16 opined that Plaintiff could carry out simple instructions, but his attention and
17 concentration was reported to be very poor, and he could not work without supervision
18 due to his seizure disorder, resulting in a moderate to marked limitation in this area. AR
19 at 411. Dr. Eisemann also opined that Plaintiff is rather irritable, but if his depression
20 were treated he would be more apt to interact well with supervisors, peers, and the public,
21 and is moderately limited in the area of social interaction. *Id.* Dr. Eisemann opined that
22 Plaintiff could adapt to simple changes in the workplace and could recognize hazards, but
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1 could not be depended upon to respond due to his seizure condition, and would also need
2 to use public transportation to get to the workplace. *Id.* Dr. Eisemann further opined that
3 if Plaintiff resumed drinking alcohol, it would greatly affect his ability to work. *Id.*
4 Finally, Dr. Eisemann opined that Plaintiff could handle his own funds. *Id.*

5 On September 23, 2011, Plaintiff saw NP Henkels at Presbyterian Medical
6 Services for an office visit. AR at 541–42. Plaintiff was seen for a medication refill. *Id.*
7 at 541. NP Henkels reported Plaintiff’s chronic problems as other convulsions; other
8 symptoms referable to back; and insomnia, other. *Id.* Plaintiff’s physical examination
9 was otherwise unremarkable. *See id.* at 541–42. NP Henkels renewed Plaintiff’s seizure
10 medication and ordered labs regarding the same, and prescribed Vistaril for Plaintiff’s
11 insomnia. *Id.* at 542, 551.

12 On October 12, 2011, Plaintiff was again seen by NP Henkels for an office visit at
13 Presbyterian Medical Services. AR at 538–40. Plaintiff was seen to discuss sleep
14 medication. *Id.* at 538. Plaintiff reported that trazodone was ineffective and hydroxyzine
15 was effective for two (2) days then ceased to be so. *Id.* NP Henkels noted Plaintiff’s
16 chronic problems as other convulsions; other symptoms referable to back; and insomnia,
17 other. *Id.* NP Henkels’s physical review of Plaintiff was otherwise unremarkable. *See*
18 *id.* at 538–39. Plaintiff was given a sample of Ambien, as well as a behavioral health
19 packet and told “that this was a very important part of getting his insomnia undercontrol
20 [sic].” *Id.* at 539.

21 On November 4, 2011, Paul Cherry, Ph.D. reviewed Plaintiff’s records and
22 completed a Psychiatric Review Technique and Mental Residual Functional Capacity

1 Assessment. AR at 413–26. In his Psychiatric Review Technique, Dr. Cherry reported
2 and RFC assessment was necessary based upon Plaintiff’s affective and anxiety-related
3 disorders. *Id.* at 413. Dr. Cherry found Plaintiff to have a medically determinable
4 impairment of depression and anxiety. *Id.* at 416–17. Regarding “B” criteria, Dr. Cherry
5 found Plaintiff to have a mild restriction of activities of daily living; mild difficulties in
6 maintaining social functioning; moderate difficulties in maintaining concentration,
7 persistence, or pace; and no repeated episodes of decompensation. *Id.* at 421. Dr. Cherry
8 also reported that the evidence does not establish the presence of the “C” criteria. *Id.* at
9 422. Dr. Cherry summarized Dr. Eisemann’s report. AR at 423. Dr. Cherry reported
10 that Plaintiff was not significantly limited in his ability to remember locations and work-
11 like procedures; to perform activities within a schedule, maintain regular attendance, and
12 be punctual within customary tolerances; to work in coordination with or proximity to
13 others without being distracted by them; to make simple work-related decisions; to ask
14 simple questions or request assistance; to maintain socially appropriate behavior and to it
15 here to basic standards of neatness and cleanliness; to be aware of normal hazards and
16 take appropriate precautions; to travel in unfamiliar places or use public transportation;
17 and to set realistic goals or make plans independently of others. *Id.* at 424–25. Dr.
18 Cherry further reported that Plaintiff was moderately limited in his ability to understand
19 and remember very short and simple instructions; to carry out very short and simple
20 instructions; to maintain attention and concentration for extended periods; to sustain an
21 ordinary routine without special supervision; to complete a normal workday and
22 workweek without interruptions from psychologically-based symptoms and to perform at
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1 a consistent pace without an unreasonable number and length of rest periods; to interact
2 appropriately with the general public; to accept instructions and respond appropriately to
3 criticism from supervisors; to get along with coworkers or peers without distracting them
4 or exhibiting behavioral extremes; and to respond appropriately to changes in the work
5 setting. *Id.* Finally, Dr. Cherry reported that Plaintiff had marked limitations in his
6 ability to understand and remember detailed instructions and to carry out detailed
7 instructions. *Id.* at 424. Accordingly, Dr. Cherry opined that Plaintiff “has moderate
8 limitations in understanding, remembering, and carrying out detailed instructions[,] . . .
9 [as well as] moderate limitations in his ability to concentrate.” *Id.* at 426. Dr. Cherry
10 further opined that Plaintiff retained the functional ability to do simple tasks in a work
11 setting environment. AR at 426.

12 On November 7, 2011, Bonnie Lammers, M.D. reviewed Plaintiff’s medical
13 records and completed a Physical Residual Functional Capacity Assessment. *Id.* at 427–
14 32. Dr. Lammers noted Plaintiff’s primary diagnosis as seizures. *Id.* at 427. Dr.
15 Lammers found that Plaintiff had no exertional limitations. *Id.* at 428. Dr. Lammers
16 further found that Plaintiff could never climb on ladders, ropes, or scaffolds. *Id.* at 429.
17 Dr. Lammers also found that Plaintiff did not have any manipulative, visual, or
18 communicative limitations. AR at 429–30. Regarding environmental limitations, Dr.
19 Lammers found Plaintiff to be unlimited, except for hazards to which he is to avoid all
20 exposure. *Id.* at 430. Dr. Lammers further noted that Plaintiff “is to avoid unprotected
21 heights, uncovered bodies of water [,] and hazardous machinery due to [his history of]
22 seizures and headaches.” *Id.*

1 On November 10, 2011, Plaintiff was seen by NP Henkels at Presbyterian Medical
2 Services for an office visit. *Id.* at 535–37. Plaintiff was seen for a medication refill of
3 Vistaril and Ambien, which Plaintiff reported to be working well. *Id.* at 535. NP
4 Henkels listed Plaintiff’s chronic problems as other convulsions; other symptoms
5 referable to back; insomnia, other; and anxiety state, unspecified. AR at 535. NP
6 Henkels’s neuro/psychiatric examination was positive for appropriate interaction,
7 consolability, and psychiatric symptoms, but negative for difficulty concentrating. *Id.* at
8 536. Plaintiff’s physical examination was otherwise unremarkable. *See id.* at 535–36.
9 NP Henkels noted that Plaintiff was noncompliant his with medication regimen, and
10 informed Plaintiff “that there would not be any refills from medical for these medications
11 and that if he wanted to stay on them he would have to keep his appointment with
12 [behavioral health].” *Id.* at 536.

13 On November 17, 2011, Plaintiff was seen at the San Juan Regional Medical
14 Center emergency department by Angela Mize, M.D. *Id.* at 435–54, 549–50, 553–59.
15 Plaintiff was brought to the emergency department via ambulance from his home after
16 having a tonic-clonic seizure. AR at 435. Dr. Mize noted that the seizure began just
17 prior to arrival, with sudden onset, and that Plaintiff also experienced headache. *Id.* at
18 435, 438, 554. Plaintiff claimed that he was compliant with his medication and had not
19 been drinking alcohol. *Id.* Dr. Mize diagnosed Plaintiff was with having a grand mal
20 seizure, suspected an underdose of his Tegretol, and adjusted the prescription
21 accordingly. *Id.* at 441. Plaintiff was discharged home. *Id.*

22 On November 21, 2011, Plaintiff was seen at Presbyterian Medical Services

1 (“PMS”) for a behavioral health assessment. AR at 525–31. Plaintiff reported that he
2 had been referred by Dr. Henkels for an assessment for anxiety and depression. *Id.* at
3 525. Plaintiff reported that Dr. Henkels had been treating his anxiety and depression for
4 a couple of months and that his memory had been increasingly impaired over the past
5 year. *Id.* Plaintiff also reported that he had pressure in his head, his neck hurt all the
6 time, he felt that he was dying, and that he had lost several family members within the
7 past year. *Id.* at 525, 530. Plaintiff recounted his history of depression and anxiety,
8 seizures, and brain injury. *Id.* at 525. Plaintiff described his current symptoms as being
9 depressed most of the day every day, insomnia, inability to concentrate, passive thoughts
10 of death, frequent panic attacks, avoidance of noisy places with lots of lights, muscle
11 tension, irritability, an inability to concentrate, and sleep disturbance. AR at 525.
12 Plaintiff reported that he has abstained from alcohol use for one (1) year. *Id.* at 527.
13 Plaintiff reviewed his history of DWIs; his family history; indicated that he wished he
14 could go to work; and reported no hobbies and no income. *Id.* at 528–29. Plaintiff was
15 diagnosed with major depression moderate; mood disorder due to a general medical
16 condition (with depressive features); panic disorder with agoraphobia; anxiety disorder
17 due to a general medical condition (TBI); alcohol dependence in full sustained remission;
18 and amphetamine dependence in full sustained remission. *Id.* at 530. Plaintiff was
19 further diagnosed with traumatic brain injury, seizures, and neck pain; problems with
20 primary support; problems related to the social environment as he is socially isolated;
21 occupational problems due to his inability to work due to seizures; and economic
22 problems as he has no income source. *Id.* Plaintiff’s diagnosis also included a GAF
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1 score of 49. AR at 530.

2 On December 5, 2011, Plaintiff saw Morgan J. Manulik, P.A.-C. for a neurologic
3 exam. *Id.* at 510–12. PA Manulik’s diagnostic impression included seizure disorder,
4 tonic-clonic; depression; sleep disturbances; history of traumatic brain injury; and history
5 of anxiety. *Id.* at 510. PA Manulik noted Plaintiff’s chief complaint as a seizure disorder
6 with associated left-sided paresthesia. *Id.* PA Manulik summarized Plaintiff’s medical
7 history noting his seizure disorder, depression, anxiety, and traumatic brain injury. *Id.* at
8 510–11. Plaintiff denied any alcohol or illicit drug use. AR at 511. PA Manulik’s
9 review of systems was unremarkable, as was his physical exam. *Id.* at 511–12. PA
10 Manulik found Plaintiff alert and oriented to person, place, and date; mentation intact
11 with appropriate memory function; mood and affect unremarkable; and no aphasia. *Id.* at
12 512. PA Manulik reported Plaintiff’s pupils were equal, round, and reactive to light and
13 accommodation; extraocular movements were intact and conjugate with no nystagmus
14 appreciated; visual fields intact to finger confrontation; facial movements and sensation
15 symmetric; tongue midline; symmetrical elevation of palate; and sternocleidomastoid and
16 trapezius function intact. *Id.* PA Manulik further reported that Plaintiff did not have any
17 peripheral nerve or dermatome pattern of sensory deficit. *Id.* PA Manulik also reported
18 that Plaintiff’s muscle bulk and tone were symmetric with strength five out of five
19 throughout. AR at 512. Plaintiff was able to perform rapid alternating movements
20 symmetrically without slowing; showed no cerebellar tremor on finger-to-nose testing;
21 and was able to perform a tandem gait. *Id.* Further, Plaintiff’s reflexes were symmetric.
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Id.

1 On December 7, 2011, Plaintiff again saw NP Henkels at Presbyterian Medical
2 Services for an office visit. *Id.* at 532–34. Plaintiff was seen for his seizure, as well as a
3 medication refill. *Id.* at 532. Plaintiff’s emergency department visit was noted, as was
4 his increased Tegretol prescription. AR at 532. Plaintiff reported taking the medication
5 as prescribed. *Id.* NP Henkels noted that Plaintiff was a poor historian at this visit. *Id.*
6 NP Henkels noted Plaintiff’s chronic problems as other convulsions; other symptoms
7 referable to back; insomnia, other; and anxiety state, and specified. *Id.* NP Henkels
8 described Plaintiff’s level of distress as awake and alert, without acute distress. *Id.* at
9 533. The examination of plaintiff was otherwise unremarkable. *See* AR at 532–34.
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12 On October 4, 2012, Plaintiff was seen by Sasi Krishna Ghanta, M.D. at El Rio
13 Community Health Center. *Id.* at 639–45. Dr. Ghanta reported Plaintiff’s appointment
14 was to establish care; for medication refills; and treatment for seizure, insomnia, back
15 pain, and anxiety. *Id.* at 639. Plaintiff reported that his last seizure episode was
16 approximately four (4) months prior; he sometimes experiences an electrical sensation
17 prior to the seizure episode; he sometimes has postictal confusion; and described his
18 symptoms to include an altered level of consciousness, aura, drooling, and urinary
19 incontinence. *Id.* Plaintiff further reported having anxious and fearful thoughts;
20 difficulty falling asleep; difficulty staying asleep; fatigue; and feelings of guilt, as well as
21 moderate, persistent, lower back pain. *Id.* Plaintiff also stated that he was not taking
22 trazodone as it was making his insomnia worse and giving him headaches. AR at 639.
23 Dr. Ghanta’s review of Plaintiff’s systems was generally unremarkable, but positive for
24 fatigue; altered level of consciousness; anxiety; aura; difficulty initiating sleep; difficulty
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1 maintaining sleep; and drooling. *Id.* at 640. Dr. Ghanta's physical examination of
2 Plaintiff was also generally unremarkable. *Id.* at 641–42. Dr. Ghanta noted that Plaintiff
3 did not have any back tenderness, straight leg raise elicited low back pain only, normal
4 strength in both lower limbs, and kyphosis present. *Id.* at 641. Regarding Plaintiff's
5 psychiatric examination, Dr. Ghanta reported he was oriented to time, place, person, and
6 situation; had a depressed affect; was negative for anhedonia; was not agitated; was
7 anxious; did not exhibit compulsive behaviors; behaved appropriately for age; had
8 normal knowledge; had normal language; was not in denial; was not euphoric; was not
9 fearful; did not have flight of ideas; was not forgetful; did not have thoughts of
10 grandiosity; denied hallucinations and hopelessness; did not have increased activity; had
11 no mood swings; had no obsessive thoughts; did not have paranoia; had normal insights;
12 exhibited normal judgment; had normal attention span and concentration; did not have
13 pressured speech; and did not have suicidal ideation. AR at 642. Dr. Ghanta further
14 reported that Plaintiff did not demonstrate the appropriate mood or affect and was
15 depressed. *Id.* Dr. Ghanta's assessment and plan included medications for Plaintiff's
16 seizures and low back pain, bloodwork, and a referral to behavioral health. *Id.*

22 On October 11, 2012, Plaintiff was referred to Southern Arizona Mental Health
23 Corporation ("SAMHC") by El Rio Community Health Center for a serious mental
24 illness ("SMI") evaluation. *Id.* at 560–601. Rainier Diaz, M.D. diagnosed Plaintiff with
25 major depressive disorder recurrent moderate; panic disorder without agoraphobia;
26 seizure disorder; other neurological disorders; economic, primary support, healthcare, and
27 occupational problems; and a GAF score of 42. *Id.* at 571, 582–83. A urine drug screen

1 was performed with negative results. *Id.* at 573, 588, 593, 594. Plaintiff reported his last
2 alcohol use as one (1) year prior. AR at 574, 580, 589. Plaintiff further reported his last
3 seizure was two (2) months prior and he was currently suffering from severe neck and
4 lower back pain. *Id.* at 574, 586, 580. Plaintiff's mental status exam reported his speech
5 to be normally responsive; affect was appropriate to thought content; mood depressed and
6 hopeless; thought process was logical and coherent; thought content included
7 preoccupations, suicidal ideation, and depressive; eye contact was culturally appropriate;
8 self-concept showed low self-esteem; Plaintiff was oriented to person, place, time, and
9 situation; motor was restless; intelligence was estimated to be average; impulse control
10 was poor; judgment was fair; insight was fair; and memory demonstrated Plaintiff could
11 not recall information at times. *Id.* at 580–81. Judith Garcia, BHT completed a Seriously
12 Mentally Ill Determination form for Plaintiff. *Id.* at 598–99. Ms. Garcia noted Plaintiff's
13 history of depression and anxiety and GAF score of 42. *Id.* at 598. Ms. Garcia's primary
14 recommendation of functional criteria noted a risk of serious harm to self or others; and
15 affective disruption causes significant damage to the person's education, livelihood,
16 career, or personal relationships. AR at 598–99. Regarding Plaintiff's capacity to
17 perform the present major role function in society, Ms. Garcia noted a major disruption of
18 role functioning; and an inability to work, attend school, or meet other developmentally
19 appropriate responsibilities. *Id.* at 599. Catherine S. Laughlin Psy.N.P. found Plaintiff to
20 have met SMI criteria. *Id.* at 600. After this assessment, Plaintiff began treatment with
21 COPE Community Services. *See id.* at 602–05.

22 On October 18, 2012, Plaintiff again saw Dr. Ghanta for an office visit. AR at

1 635–38. The appointment was a follow-up, as well as a check-up regarding Plaintiff's
2 sore throat. *Id.* at 635. Plaintiff reported that he had been seen by Dr. Diaz at SAMHC,
3 and had a follow-up appointment scheduled. *Id.* Dr. Ghanta noted Plaintiff's chronic
4 problems as insomnia, anxiety state, pain in lower back, seizure disorder, and depression.
5 *Id.* Dr. Ghanta's examination showed Plaintiff had a fever, nasal drainage, sore throat,
6 and cough. *Id.* at 636. Dr. Ghanta assessed and acute upper respiratory infection, acute
7 sinusitis, depression, and low back pain. AR at 637. Dr. Ghanta prescribed amoxicillin
8 for Plaintiff's cold. *Id.* On October 26, 2012, Plaintiff underwent an initial intake at
9 COPE Community Services and a Recommended Crisis Plan was created. *Id.* at 611–13,
10 616. Plaintiff reported having recently moved from New Mexico and that he had been
11 sober from alcohol for eight (8) months. *Id.* at 616. Louis Gall, BHT reported Plaintiff
12 to have limited insight into his presenting problem and that he deferred to his wife
13 numerous times. *Id.*

18 On November 7, 2012, Plaintiff underwent a psychiatric diagnostic interview
19 examination with Francisco Garcia, M.D. AR at 620. Dr. Garcia reported that Plaintiff's
20 appearance was casual; concentration was poor; affect was restricted; speech was normal;
21 psychomotor was retarded; mood was depressed; insight was fair; and judgment was fair.
22 *Id.* Dr. Garcia further reported that Plaintiff denied any delusions, hallucinations, and
23 homicidal or suicidal ideations and noted Plaintiff to be oriented ×3. *Id.* Dr. Garcia
24 noted that Plaintiff had a history of grand mal seizures, recurrent episodes of depression,
25 and alcohol dependence from which he had been sober for seven (7) months. *Id.* Dr.
26 Garcia further noted that Plaintiff had been prescribed amitriptyline and citalopram, but
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1 quit taking them because the medication made him feel suicidal. *Id.* Dr. Garcia also
2 noted that Plaintiff had been given Lorazepam, but had run out. AR at 620. Dr. Garcia
3 diagnosed recurrent alcohol dependence in partial remission and prescribed sertraline and
4 Lorazepam. *Id.*

6 On December 10, 2012, Plaintiff saw Dr. Garcia for pharmacologic management.
7 *Id.* at 626. Dr. Garcia reported Plaintiff's appearance was casual; concentration was fair;
8 affect was apprehensive; speech was normal; psychomotor was neutral; mood was
9 anxious; insight was fair; and judgment was fair. *Id.* Dr. Garcia further reported that
10 Plaintiff denied delusions; hallucinations; and homicidal or suicidal ideation. *Id.* Dr.
11 Garcia noted Plaintiff to be oriented ×3. AR at 626. Plaintiff reported that he was still
12 feeling anxious when going out and being around people, and complained of insomnia.
13 *Id.* Dr. Garcia discontinued Lorazepam and switched to diazepam and increased
14 Plaintiff's sertraline dosage. *Id.* On December 18, 2012, Plaintiff saw Dr. Ghanta for an
15 office visit. *Id.* at 631–34. Plaintiff's visit included a follow-up for seizure, that he
16 reported having a couple weeks prior. *Id.* at 631. Plaintiff described the seizure as a
17 sudden shock like sensation with confusion and blacking out for a few seconds, but
18 without jerking of arms and legs or incontinence. AR at 631. Plaintiff confirmed that he
19 was taking the lamotrigine and carbamazepine. *Id.* Dr. Ghanta's physical examination
20 was unremarkable. *Id.* at 632–33. Dr. Ghanta's assessment and plan included continuing
21 medications for Plaintiff's seizure disorder and a neurology referral; continuing Naprosyn
22 and starting gabapentin for his low back pain; and following up at SAMHC for his
23 depression. *Id.* at 633.

1 On February 4, 2013, Plaintiff was seen by Dr. Garcia at COPE for a medication
2 follow-up. *Id.* at 681–82. Plaintiff reported that he was doing well, but that the diazepam
3 was too strong and making it difficult to wake up in the morning. AR at 681. Dr. Garcia
4 reported Plaintiff's speech was normal; memory was mildly impaired; thought process
5 was concrete and simple; concentration was poor; fund of knowledge was mildly limited;
6 judgment was limited; insight was limited; mood was appropriate for the situation; affect
7 was appropriate; language was normal; and thoughts were normal. *Id.* Dr. Garcia further
8 reported Plaintiff was oriented ×3 and compliant with medications. *Id.* Dr. Garcia also
9 reported that Plaintiff denied delusions, hallucinations, and homicidal or suicidal
10 ideation. *Id.* Dr. Garcia decreased Plaintiff's diazepam dosage and continued his
11 sertraline. *Id.* at 682. Dr. Garcia reported Plaintiff's Global Risk Assessment as
12 moderate, meaning one or more chronic illnesses with mild exacerbation or two or more
13 stable chronic illnesses. AR at 682.

14 On April 17, 2013, Plaintiff followed up with Dr. Garcia at COPE. *Id.* at 672–73.
15 Plaintiff reported some mood improvement, but was still feeling anxious and did not like
16 the way Valium made him feel. *Id.* at 672. Dr. Garcia reported Plaintiff's speech was
17 normal; memory was age-appropriate; thought processes were logical and coherent;
18 concentration was fair; fund of knowledge was age-appropriate; judgment was fair;
19 insight was fair; mood was anxious; affect was apprehensive; and language was normal.
20 *Id.* Dr. Garcia further reported that Plaintiff was oriented ×4 and did not have any
21 abnormal or psychotic thoughts. *Id.* Dr. Garcia also noted that Plaintiff denied delusions,
22 hallucinations, and homicidal or suicidal ideations. *Id.* Dr. Garcia reported Plaintiff was
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1 compliant with his medication. AR at 672. Dr. Garcia discontinued Valium and started a
2 prescription for clonazepam and continued the sertraline. *Id.* at 673. Dr. Garcia reported
3 Plaintiff's Global Risk Assessment as low, meaning one stable chronic illness, such as
4 well-controlled depression. *Id.*

5 On April 22, 2013, Plaintiff was seen by Dr. Ghanta for an office visit. *Id.* at 653–
6 60. Plaintiff's appointment included a seizure follow-up, as well as ongoing treatment
7 for his chronic conditions, including anxiety, depression, insomnia, low back pain, and
8 seizure disorder. *Id.* at 657. Plaintiff reported that he had not seen a neurologist due to
9 finances and stated that he had stopped taking gabapentin due to its side effects. AR at
10 657. Dr. Ghanta's examination was unremarkable. *Id.* at 658–59. Dr. Ghanta reported
11 that Plaintiff's low back was without tenderness, straight leg raise was negative, there
12 was normal strength in both lower limbs, and plaintiff was able to walk on his tip toes
13 and heal. *Id.* at 659. Dr. Ghanta's assessment and plan included instructions for Plaintiff
14 to continue medications and use a heating pad for low back pain; continue medications
15 for his seizure disorder, as well as a discussion regarding fall and seizure precautions; and
16 a follow up with his psychiatrist for depression. *Id.* at 655, 659–60. On the same date,
17 Plaintiff underwent diagnostic radiology of his lumbosacral spine. *Id.* at 653. Per
18 Granstrom, M.D. reported five (5) normal lumbar vertebrae with the intra-vertebral disc
19 spaces preserved. AR at 653. Dr. Granstrom further noted small osteophytes anteriorly
20 on L3 and 4 suggesting mild degenerative changes and no posterior osteophytes. *Id.* Dr.
21 Granstrom also noted normal facet joints and intravertebral foramina, and unremarkable
22 adjacent soft tissues. *Id.*

1 On May 13, 2013, Plaintiff saw Dr. Ghanta for a follow-up visit regarding his
2 chronic conditions. *Id.* at 647–50. Dr. Ghanta reported Plaintiff’s lower back pain and
3 seizure disorder were controlled and directed the use of a heating pad and continuation of
4 medications. *Id.* at 647. Dr. Ghanta further noted Plaintiff’s major depressive disorder
5 was fairly controlled, and directed follow-up at COPE. AR at 647.
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9 **II. STANDARD OF REVIEW**

10 The factual findings of the Commissioner shall be conclusive so long as they are
11 based upon substantial evidence and there is no legal error. 42 U.S.C. §§ 405(g),
12 1383(c)(3); *Tommasetti v. Astrue*, 533 F.3d 1035, 1038 (9th Cir. 2008). This Court may
13 “set aside the Commissioner’s denial of disability insurance benefits when the ALJ’s
14 findings are based on legal error or are not supported by substantial evidence in the
15 record as a whole.” *Tackett v. Apfel*, 180 F.3d 1094, 1097 (9th Cir. 1999) (citations
16 omitted); *see also Treichler v. Comm’r of Soc. Sec. Admin.*, 775 F.3d 1090, 1098 (9th
17 Cir. 2014).

18 Substantial evidence is “‘more than a mere scintilla[,] but not necessarily a
19 preponderance.’” *Tommasetti*, 533 F.3d at 1038 (quoting *Connett v. Barnhart*, 340 F.3d
20 871, 873 (9th Cir. 2003)); *see also Garrison v. Colvin*, 759 F.3d 995, 1009 (9th Cir.
21 2014). Further, substantial evidence is “such relevant evidence as a reasonable mind
22 might accept as adequate to support a conclusion.” *Parra v. Astrue*, 481 F.3d 742, 746
23 (9th Cir. 2007). Where “the evidence can support either outcome, the court may not
24 substitute its judgment for that of the ALJ.” *Tackett*, 180 F.3d at 1098 (citing *Matney v.*
25

1 *Sullivan*, 981 F.2d 1016, 1019 (9th Cir. 1992)); *see also Massachi v. Astrue*, 486 F.3d
2 1149, 1152 (9th Cir. 2007). Moreover, the court may not focus on an isolated piece of
3 supporting evidence, rather it must consider the entirety of the record weighing both
4 evidence that supports as well as that which detracts from the Secretary's conclusion.
5 *Tackett*, 180 F.3d at 1098 (citations omitted).

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8 **III. ANALYSIS**

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10 **A. *The Five-Step Evaluation***

11 The Commissioner follows a five-step sequential evaluation process to assess
12 whether a claimant is disabled. 20 C.F.R. § 404.1520(a)(4). This process is defined as
13 follows: Step one asks is the claimant “doing substantial gainful activity[?]” If yes, the
14 claimant is not disabled; step two considers if the claimant has a “severe medically
15 determinable physical or mental impairment[.]” If not, the claimant is not disabled; step
16 three determines whether the claimant’s impairments or combination thereof meet or
17 equal an impairment listed in 20 C.F.R. Pt. 404, Subpt. P, App.1. If not, the claimant is
18 not disabled; step four considers the claimant’s residual functional capacity and past
19 relevant work. If claimant can still do past relevant work, then he or she is not disabled;
20 step five assesses the claimant’s residual functional capacity, age, education, and work
21 experience. If it is determined that the claimant can make an adjustment to other work,
22 then he or she is not disabled. 20 C.F.R. § 404.1520(a)(4)(i)-(v).

23 In the instant case, the ALJ found that Plaintiff met the insured status requirements
24 of the Social Security Act through December 31, 2012, and was not engaged in

1 substantial gainful activity since his amended alleged onset date of January 1, 2010.³ AR
2 at 13. At step two of the sequential evaluation, the ALJ found that “[t]he claimant has the
3 following severe impairments: seizures; depression; headache; anxiety disorder;
4 insomnia; history of drug and alcohol abuse in full-sustained remission (20 CFR
5 404.1520(c) and 416.920(c)).” *Id.* At step three, the ALJ found that “[t]he claimant does
6 not have an impairment or combination of impairments that meets or medically equals
7 the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1
8 (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925 and 416.926).” *Id.* at
9 14. Prior to step four and “[a]fter careful consideration of the entire record,” the ALJ
10 determined that “the claimant has the residual functional capacity to perform medium
11 work as defined in 20 CFR 404.1567(c) and 416.967(c) except the claimant can never
12 climb ropes, ladders, or scaffolds; must avoid all exposure to unprotected heights; is
13 limited to simple, routine, and repetitive tasks; can only occasionally interact with the
14 public; can only occasionally interact with co-workers; and must not be in an isolated
15 work area.” AR at 16. At step four, the ALJ found that “[t]he claimant is unable to
16 perform any past relevant work (20 CFR 404.1565 and 416.965).” *Id.* at 20.
17 Accordingly, at step five, the ALJ found that “[c]onsidering the claimant’s age,
18 education, work experience, and residual functional capacity, there are jobs that exist in
19 significant numbers in the national economy that the claimant can perform (20 CFR
20 404.1569, 404.1569(a), 416.969, and 416.969(a)).” *Id.*

21 Plaintiff asserts that the ALJ erred in failing to consider all of Plaintiff’s
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28³ See FN 2, *supra*.

1 impairments in posing a hypothetical question to the vocational expert, improperly
2 imposing her own medical opinion, failing to fully consider Plaintiff's statements and
3 testimony about the limiting effects of his impairments, and in weighing the reports of
4 Plaintiff's activities of daily living. Pl.'s Opening Br. (Doc. 19) at 9, 12–22.

5 ***B. Plaintiff's Symptoms***

6 **1. Legal standard**

7 “To determine whether a claimant’s testimony regarding subjective pain or
8 symptoms is credible, an ALJ must engage in a two-step analysis.” *Lingenfelter v.
9 Astrue*, 504 F.3d 1028, 1035–36 (9th Cir. 2007). First, “a claimant who alleges disability
10 based on subjective symptoms ‘must produce objective medical evidence of an
11 underlying impairment which could reasonably be expected to produce the pain or other
12 symptoms alleged[.]’” *Smolen v. Chater*, 80 F.3d 1273, 1281–82 (9th Cir. 1996)
13 (quoting *Bunnell v. Sullivan*, 947 F.2d 341, 344 (9th Cir. 1991) (*en banc*) (internal
14 quotations omitted)); *see also Ghanim v. Colvin*, 763 F.3d 1154, 1163 (9th Cir. 2014).
15 Further, “the claimant need not show that her impairment could reasonably be expected
16 to cause the severity of the symptom she has alleged; she need only show that it could
17 reasonably have caused some degree of the symptom.” *Smolen*, 80 F.3d at 1282
18 (citations omitted); *see also Trevizo v. Berryhill*, — F.3d —, 2017 WL 4053751, *9 (9th
19 Cir. Sept. 14, 2017). “Nor must a claimant produce ‘objective medical evidence of the
20 pain or fatigue itself, or the severity thereof.’” *Garrison v. Colvin*, 759 F.3d 995, 1014
21 (9th Cir. 2014) (quoting *Smolen*, 80 F.3d at 1282). “[I]f the claimant meets this first test,
22 and there is no evidence of malingering, ‘the ALJ can reject the claimant’s testimony
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1 about the severity of her symptoms only by offering specific, clear and convincing
2 reasons for doing so.”” *Lingenfelter*, 504 F.3d at 1036 (quoting *Smolen*, 80 F.3d at 1281);
3 *see also Burrell v. Colvin*, 775 F.3d 1133, 1137 (9th Cir. 2014) (rejecting the contention
4 that the “clear and convincing” requirement had been excised by prior Ninth Circuit case
5 law). “This is not an easy requirement to meet: ‘The clear and convincing standard is the
6 most demanding required in Social Security cases.’” *Garrison*, 759 F.3d at 1015
7 (quoting *Moore v. Comm’r of Soc. Sec. Admin.*, 278 F.3d 920, 924 (9th Cir. 2002)).

8
9 “Factors that an ALJ may consider in weighing a claimant’s credibility include
10 reputation for truthfulness, inconsistencies in testimony or between testimony and
11 conduct, daily activities, and ‘unexplained, or inadequately explained, failure to seek
12 treatment or follow a prescribed course of treatment.’” *Orn v. Astrue*, 495 F.3d 625, 636
13 (9th Cir. 2007) (quoting *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989)); *see also*
14 *Ghanim*, 763 F.3d at 1163. The Ninth Circuit Court of Appeals has “repeatedly warned[,
15 however,] that ALJs must be especially cautious in concluding that daily activities are
16 inconsistent with testimony about pain, because impairments that would unquestionably
17 preclude work and all the pressures of a workplace environment will often be consistent
18 with doing more than merely resting in bed all day.” *Garrison*, 759 F.3d at 1016
19 (citations omitted). Furthermore, “[t]he Social Security Act does not require that
20 claimants be utterly incapacitated to be eligible for benefits, and many home activities
21 may not be easily transferable to a work environment where it might be impossible to rest
22 periodically or take medication.” *Smolen*, 80 F.3d at 1287 n. 7 (citations omitted). The
23 Ninth Circuit Court of Appeals has noted:
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The critical differences between activities of daily living and activities in a full-time job are that a person has more flexibility in scheduling the former than the latter, can get help from other persons . . . , and is not held to a minimum standard of performance, as she would be by an employer. The failure to recognize these differences is a recurrent, and deplorable, feature of opinions by administrative law judges in social security disability cases.

Garrison, 759 F.3d at 1016 (quoting *Bjornson v. Astrue*, 671 F.3d 640, 647 (7th Cir. 2012)) (alterations in original). “While ALJs obviously must rely on examples to show why they do not believe that a claimant is credible, the data points they choose must *in fact* constitute examples of a broader development to satisfy the applicable ‘clear and convincing’ standard.” *Id.* at 1018 (emphasis in original) (discussing mental health records specifically). “Inconsistencies between a claimant’s testimony and the claimant’s reported activities provide a valid reason for an adverse credibility determination. *Burrell*, 775 F.3d at 1137 (citing *Light v. Soc. Sec. Admin.*, 119 F.3d 789, 792 (9th Cir. 1997)).

2. ALJ findings

Here, the ALJ properly delineated the two-step process for assessing Plaintiff's symptom testimony. AR at 16. The ALJ then found that Plaintiff's "subjective allegations are out of proportion to the objective medical evidence." *Id.* at 19.

a. Medication non-compliance

The ALJ stated that “despite the complaints of allegedly disabling seizure symptoms, there is evidence the claimant has not been entirely compliant in taking prescribed medications[;][t]he claimant reported he experienced a seizure after he ran out of medications during a visit to Farmington on July 18, 2011.” AR at 19. “Failure to

1 follow prescribed treatment may ‘cast doubt on the sincerity of the claimant’s pain
2 testimony.’” *Trevizo v. Berryhill*, — F.3d —, 2017 WL 4053751, *11 (9th Cir. Sept. 14,
3 2017) (citing *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989)). A review of the record,
4 however, shows that Plaintiff is generally compliant with his medication. AR at 435,
5 438, 441, 536, 672, 681. Moreover, on the same note indicating that Plaintiff’s seizure
6 was a result of running out of medication, CNP Addington reported that Plaintiff was
7 having daily suicidal ideation and accompanied him to behavioral health for intake. *Id.* at
8 404, 548. Additionally, Plaintiff experienced a grand mal seizure while on his seizure
9 medication. *Id.* at 435.
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12 Furthermore, “[d]isability benefits may not be denied because of the claimant’s
13 failure to obtain treatment he cannot obtain for lack of funds.” *Trevizo*, 2017 WL
14 4053751 at *11 (quoting *Gamble v. Chater*, 68 F.3d 319, 321 (9th Cir. 1995)). The
15 record reflects that Plaintiff had not filled two of his prescriptions due to cost and
16 similarly foregone needed dental work. AR at 407, 410. The single data point chosen by
17 the ALJ with regard to Plaintiff’s medication compliance does not support a broader
18 finding of unreliability. *See Garrison*, 759 F.3d at 1018.
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21 **b. Headaches**

22 The ALJ stated “[r]egarding the claimant’s alleged headaches, a CT of the
23 claimant’s head taken on July 27, 2011 was negative and a physical examination showed
24 no significant abnormalities.” AR at 19. Plaintiff is not required to “produce objective
25 medical evidence of the pain or fatigue itself, or the severity thereof.” *Garrison*, 759
26 F.3d at 1014 (quotations and citations omitted). Moreover, Plaintiff’s CT scan from July
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1 4, 2011—twenty-three (23) days prior—indicated “[c]hronic right frontal and right
2 parietal infarcts[.] AR at 338, 339, 398, 481, 482, 493, 514. Additionally, Dr. Orbelo
3 read and wrote the reports on both scans, which were close in time. *See id.* at 338, 339,
4 398, 459–60, 463, 481, 482, 493, 513, 514, 552. Plaintiff’s traumatic brain injury and
5 seizure disorder are well documented with evidence that headaches are associated with
6 the same. As such, the ALJ did not point to any specific, clear and convincing reason for
7 discounting Plaintiff’s testimony regarding the severity of his headaches. *See*
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9 *Lingenfelter*, 504 F.3d at 1036.

c. Inconsistent statements

The ALJ noted that “the claimant has made inconsistent statements regarding matters relevant to the issue of disability.” AR at 19. The ALJ pointed to two instances in which Plaintiff’s statements regarding his use of illicit drugs were inconsistent with the medical record. *Id.* Inconsistent or dishonest statements regarding past drug and alcohol use are proper grounds for discounting a claimant’s testimony. *Thomas v. Barnhart*, 278 F.3d 947, 959 (9th Cir. 2002). The Court finds, however, that “[t]his does not constitute substantial evidence supporting a finding that [Plaintiff’s] symptoms were not as severe as [he] testified, particularly in light of the extensive medical record objectively verifying his claims.” *Trevizo*, 2017 WL 4053751, *12.

d. Conclusion

Based upon the foregoing, the Court finds that the ALJ failed to provide specific, clear and convincing reasons for discounting Plaintiff's testimony which are supported by substantial evidence in the record. *See Lingenfelter*, 504 F.3d at 1036; *Tommasetti v.*

1 *Astrue*, 533 F.3d 1035, 1040 (9th Cir. 2008).

2 **C. Remand for Further Proceedings**

3 “[T]he decision whether to remand the case for additional evidence or simply to
4 award benefits is within the discretion of the court.”” *Rodriguez v. Bowen*, 876 F.2d 759,
5 763 (9th Cir. 1989) (*quoting Stone v. Heckler*, 761 F.2d 530, 533 (9th Cir. 1985)).
6 “Remand for further administrative proceedings is appropriate if enhancement of the
7 record would be useful.” *Benecke v. Barnhart*, 379 F.3d 587, 593 (9th Cir. 2004) (*citing*
8 *Harman v. Apfel*, 211 F.3d 1172, 1178 (9th Cir. 2000)). Conversely, remand for an award
9 of benefits is appropriate where:

10 (1) the ALJ failed to provide legally sufficient reasons for rejecting the
11 evidence; (2) there are no outstanding issues that must be resolved before a
12 determination of disability can be made; and (3) it is clear from the record
13 that the ALJ would be required to find the claimant disabled were such
14 evidence credited.

15 *Benecke*, 379 F.3d at 593 (citations omitted). Where the test is met, “we will not remand
16 solely to allow the ALJ to make specific findings. . . . Rather, we take the relevant
17 testimony to be established as true and remand for an award of benefits.” *Id.* (citations
18 omitted); *see also Lester v. Chater*, 81 F.3d 821, 834 (9th Cir. 1995). “Even if those
19 requirements are met, though, we retain ‘flexibility’ in determining the appropriate
20 remedy.” *Burrell v. Colvin*, 775 F.3d 1133, 1141 (9th Cir. 2014).

21 Here, the ALJ committed legal error in rejecting Plaintiff’s symptom testimony.
22 The Court finds that remand is appropriate in this case. The ALJ is instructed to reassess
23 Plaintiff’s symptom testimony, as well as the lay witness testimony which was
24 discounted, in part because of the same. *See* AR at 20. The ALJ is further instructed to

1 reassess Plaintiff's activities of daily living and the limitations that they impose based on
2 her revised analysis of Plaintiff's symptoms. Additionally, reassessment of Plaintiff's
3 testimony may impact the VE testimony and require additional inquiry. *See Matthews v.*
4 *Shalala*, 10 F.3d 678, 681 (9th Cir. 1993) ("[i]f a vocational expert's hypothetical does
5 not reflect all the claimant's limitations, then the expert's testimony has no evidentiary
6 value to support a finding that the claimant can perform jobs in the national economy."
7 (internal quotation marks and citation omitted)). Finally, the ALJ shall correct Plaintiff's
8 alleged onset date based upon the administrative record.
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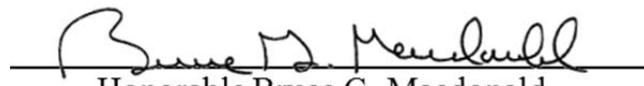
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12 **V. CONCLUSION**
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14 In light of the foregoing, the Court REVERSES the ALJ's decision and the case is
15 REMANDED for further proceedings consistent with this decision.
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17 Accordingly, IT IS HEREBY ORDERED that:
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- 19 1) Plaintiff's Opening Brief (Doc. 21) is GRANTED;
- 20 2) The Commissioner's decision is REVERSED and REMANDED;
- 21 3) Upon remand, the Appeals Council will remand the case back to the ALJ
on an open record; and
- 22 4) The Clerk of the Court shall enter judgment, and close its file in this matter.

23 Dated this 21st day of September, 2017.
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26 
27 Honorable Bruce G. Macdonald
28 United States Magistrate Judge